Thank you for your interest in attending Camp Sunshine. Pages 1-3 of the application are for families to complete. Pages 4-6 are for your hematology team to complete.

Eligibility Guidelines

- If both parents are unable to attend, a second adult may attend as a support person and should be included on the application.
- Immunization records are required for everyone under 26 years of age.
- Completed applications will be reviewed on a first-come, first-served basis, and should be received at least one month prior to the session start date. (If seeking to apply within one month of a program, please call Camp Sunshine to inquire about availability.)
- Families may apply to attend once per calendar year.

Things to Know About Camp

- Meals, lodging, and activities are all provided at no cost to families, thanks to the generosity of our donors.
- A physician is present on-site during all Camp Sunshine sessions.
- Family suites can comfortably sleep 6 and include a private bathroom, heat/AC, a mini-fridge, and microwave oven.
- Transportation assistance may be available for families who would otherwise be unable to attend Camp. Funding is prioritized for families attending for the first time. Please indicate your request for transportation funding on the first page of the application. If requested, you will receive further information at the time of acceptance.
- You will be contacted upon receipt of your application. Acceptances and other updates will be provided as soon as possible.

Applications may be mailed or faxed to:
Camp Sunshine
35 Acadia Road
Casco, ME 04015
Phone: (207) 655-3800
Fax: (207) 655-3825
www.campsunshine.org
2018 Fanconi Anemia Application Checklist

Please use the following checklist to ensure that your family’s application is complete.

- **Family Forms**
  - Pages 1-3 of the application, to be completed by the parent/guardian

- **Physician Forms**
  - Pages 4-6 of the application, to be completed by your child’s specialist

- **Immunization Records**
  - A complete and up-to-date immunization record must be included for each person under 26 years of age who is applying to attend Camp.
  - For the optimal health and safety of all campers, staff, and volunteers, Camp Sunshine requires that all campers who can receive immunizations meet the age-appropriate immunization schedule as set forth by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention.
  - At a minimum, campers aged 5 years and older should meet the same immunization requirements as those for school-aged children set forth in the State of Maine School Immunization Law (20-A MRSA §§6352-6358):
    - 5 DTaP (4 DTaP if the 4th is given on or after the 4th birthday)
    - 4 Polio (if the 4th dose is given before the 4th birthday, an additional age-appropriate inactivated polio immunization should be given on or after the 4th birthday)
    - 2 MMR (measles, mumps, rubella)
    - 1 Varicella (chickenpox) or reliable history of disease
  - Camp Sunshine also requires that children aged 11 and older receive meningococcal vaccine and TDaP booster prior to attendance.

- **Health History Forms**
  - A separate Health History form is required for each person (including adults) planning to attend Camp, with the exception of the child with Fanconi Anemia. The Health History forms do not require a physician signature.
2018 Fanconi Anemia Program
June 29 – July 4
Family Application

Please print clearly using black or blue ink.

CAMPER INFORMATION

FA Camper's last name ___________________ FA Camper's first name ___________________

Name as you would like it to appear on the FA Camper's nametag ___________________

Gender __________________________________ Date of Birth ______/_____/_______

Diagnosis ________________________________ Date of Diagnosis ______/_____/_______

Address ________________________________ Apt ______ City __________ State ______ Zip ______

Home telephone _________________________ E-mail ________________________________

Treatment Center ________________________

Address ________________________________ City __________ State ______ Zip ______

Physician (Specialist) ____________________ Telephone _______ Fax ______________

Social Worker ___________________________ Telephone _______ Fax ______________

Health Insurance Company ________________ Telephone ______________

Policy Holder ____________________________ Policy No. ____________________ Group No. __________

Date of Arrival: ______/_____/_______ Date of Departure: ______/_____/_______

Note: To accommodate as many families as possible, only one housing unit will be available per accepted family. FARF-scheduled educational sessions will begin Friday, June 29 and conclude the evening of Monday, July 2. Support groups and recreational activities will continue for FA families until Wednesday morning, July 4. FARF has reserved a number of accommodations for families at nearby Point Sebago Resort for Friday, June 29 through checkout on the morning of Tuesday, July 3. In the event that you are staying at Point Sebago and wish to avail yourselves of the rest of the Camp Sunshine program, you will need to relocate to Camp Sunshine on the morning of July 3.

Is your family is willing to share a room on the Camp Sunshine campus? □ Yes □ No

Is your family willing to stay at Point Sebago? □ Yes □ No Is your family willing to commute? □ Yes □ No

Prior Attendance: This is our (please circle one) 1st time 2nd time 3rd time 4th time ______th time at Camp.

How did you hear about Camp Sunshine? ______________________________

FOR OFFICE USE ONLY

□ Family Forms □ Immunizations □ Physician Forms □ Health History Forms
INFORMATION FOR FAMILIES WITH CHILDREN UNDER AGE 18

Name of parent(s) or guardian(s) child lives with:

Marital status (please indicate marital status of parents and explain any particular familial circumstances and/or custodial arrangements of which we should be aware):

Parent/Guardian 1:
Relationship to child:
Date of Birth ______/_____/______
Address ____________________________________________________________
City, State, Zip ____________________________
Home Phone ______________________________
Cellular phone _____________________________
E-mail _____________________________________
Employer __________________________________
Have you been in the Armed Forces?
Have you been in the Reserves?

Parent/Guardian 2:
Relationship to child:
Date of Birth ______/_____/______
Address ____________________________________________________________
City, State, Zip ____________________________
Home Phone ______________________________
Cellular phone _____________________________
E-mail _____________________________________
Employer __________________________________
Have you been in the Armed Forces?
Have you been in the Reserves?

Emergency Contact (someone who will not be attending Camp with you)
Name ____________________________ Relationship ____________________________ Telephone ____________________________

WHO WILL BE ATTENDING CAMP WITH THE FA CAMPER?
One adult support person may accompany a single parent/guardian or a parent/guardian whose partner cannot attend.

Adult/Parent/Legal Guardian Names

1. ____________________________________________ Relationship to camper __________________ Medical or Emotional diagnosis or concern? Yes No
2. ____________________________________________ Relationship to camper __________________ Medical or Emotional diagnosis or concern? Yes No

Sibling’s/ Camper’s Children/Support Person’s Child(ren)’s Names

1. ____________________________________________ Relationship/age at time of Camp ______/____ yr Medical or Emotional concern?
2. ____________________________________________ Relationship/age at time of Camp ______/____ yr Yes
3. ____________________________________________ Relationship/age at time of Camp ______/____ yr Yes
4. ____________________________________________ Relationship/age at time of Camp ______/____ yr Yes
5. ____________________________________________ Relationship/age at time of Camp ______/____ yr Yes
6. ____________________________________________ Relationship/age at time of Camp ______/____ yr Yes

*PLEASE NOTE: ALL CHILDREN UNDER THE AGE OF 18 MUST BE ACCOMPANIED BY A PARENT AND/OR LEGAL GUARDIAN WHEN ATTENDING CAMP. IF A LEGAL GUARDIAN WILL BE ACCOMPANYING A CHILD TO CAMP, ORIGINAL NOTARIZED COURT DOCUMENTATION CONFIRMING THE GUARDIANSHIP MUST BE INCLUDED WITH THIS APPLICATION. IF YOUR MARITAL STATUS IS SEPARATED OR DIVORCED, YOU MAY RECEIVE SUPPLEMENTAL MATERIALS AND PARENTS/LEGAL GUARDIANS MAY BE REQUIRED TO PROVIDE ADDITIONAL INFORMATION.

FA CAMPER’S GENERAL MEDICAL HISTORY

THE MORE INFORMATION WE HAVE, THE BETTER UNDERSTANDING WE WILL HAVE OF THE FA CAMPER’S NEEDS.

Primary language:_____________________________________________________

Additional medical problems (such as asthma, diabetes, etc.):_____________________________________________________

Drug allergies:_____________________________________________________

Dietary restrictions or food allergies:________________________________________

Physical limitations:_____________________________________________________

Mobility (e.g., wheelchair, crutches, amputations):________________________

Special needs/care requirements (vision/hearing loss):________________________

Does the FA camper have seizures? Yes No If so, how frequently do they occur?

Please describe the type of seizure:________________________________________

What treatment is necessary for the seizures? ________________________________ When was the last seizure? __________

Is the FA camper incontinent? Yes No If yes: Bladder Bowel Is catheterization needed? Yes No

Are you facing a major medical decision regarding the FA camper in the coming year? Yes No If so, please explain

Please provide any additional information that would be helpful in our assessment ________________________________

(11/6/2017) 2
Permission to use photographs, video tape and/or audio tape of you and/or your family

On behalf of myself and my family, I do hereby give Camp Sunshine, without consideration or compensation, permission to use photographs, videotape, and/or audiotape that may be taken or recorded while my child and family are attending Camp for promotional, educational, or fundraising activities. It is my understanding that these likenesses may be used to promote public and professional understanding and support of the program. I waive any right that I may have to inspect or approve the finished product or the use to which it may be applied.

Parent/Guardian/Other Adult ______________________________ Signature __________________________ Date __________ (please print)

Parent/Guardian/Other Adult ______________________________ Signature __________________________ Date __________ (please print)

Permission to use photographs and/or videotape of you and/or your family for postings on Social Media.

On behalf of myself and my family, I do hereby give Camp Sunshine, without consideration or compensation, permission to use photographs and/or videotape that may be taken or recorded while my child and family are attending Camp for postings on social media including but not limited to postings on Camp Sunshine at Sebago Lake's official facebook page. I waive any right that I may have to inspect or approve the finished product or the use to which it may be applied.

Parent/Guardian/Other Adult ______________________________ Signature __________________________ Date __________ (please print)

Parent/Guardian/Other Adult ______________________________ Signature __________________________ Date __________ (please print)

Permission to use family name in connection with fundraising efforts

I give my permission for Camp Sunshine to use my/my family's name to help raise funds to support the Camp Sunshine program. I understand that I am to receive no compensation for the use of my/my family's name for these purposes.

Parent/Guardian/Other Adult ______________________________ Signature __________________________ Date __________ (please print)

Parent/Guardian/Other Adult ______________________________ Signature __________________________ Date __________ (please print)

AUTHORIZATION FOR CAMP SUNSHINE TO PROVIDE MEDICAL TREATMENT

I hereby give my consent for Camp Sunshine’s medical personnel to provide any and all reasonable and necessary medical treatment for my children.

(Please include all of the children in your family who will be attending Camp Sunshine).

<table>
<thead>
<tr>
<th>All Children’s Names</th>
<th>Date of Birth</th>
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<tbody>
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<td>1.</td>
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<td>6.</td>
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</tr>
</tbody>
</table>

This authorization shall remain in effect while we are attending Camp Sunshine at Sebago Lake in Casco, Maine.

Parent/Guardian/Other Adult ______________________________ Signature __________________________ Date __________ (please print)

Parent/Guardian/Other Adult ______________________________ Signature __________________________ Date __________ (please print)

I understand and agree that information disclosed regarding any of the individuals named in this application and related documents may be disclosed or otherwise released to appropriate organizations or individuals (including, but not limited to: members of the Camp Sunshine staff, insurance companies, and physicians) in connection with attendance at Camp Sunshine at Sebago Lake, Inc. I hereby confirm that the above information is true and accurate and that once accepted, I agree to update this information as you may request.

I understand that Camp Sunshine reserves the right to accept or decline any application for any reason.

Parent/Guardian/Other Adult ______________________________ Signature __________________________ Date __________ (please print)

Parent/Guardian/Other Adult ______________________________ Signature __________________________ Date __________ (please print)
Physicians’ Guidelines for Camp Sunshine Applications

The medical guidelines for patients who wish to attend Camp Sunshine are as follow:

1. Campers are considered medically acceptable to participate in the program if they can be expected to be in good general health at the time of the camp session. We regret that we cannot accommodate patients with renal disease who are on hemodialysis.

2. Campers should undergo laboratory testing, when appropriate, prior to attending camp. A “Late Changes” form is to be sent to Camp 1-3 weeks in advance of the patient’s attendance, noting up-to-date laboratory tests and medication changes.

3. The Physical Examination form must be completed by the camper’s subspecialty team and returned along with the camper’s application.

4. Campers should not require any therapy during Camp other than treatment usually administered at home, with the exception of methotrexate or colony stimulating factors.

5. Campers should not require any form of special medical care during the week of Camp, e.g. transfusions.

6. Arrangements for laboratory investigations at Camp should be made in advance by the referring physician, or by the family with the Camp physician upon arrival.

7. Children or other susceptible family members who have been exposed to varicella (chickenpox) within three weeks of a camp session cannot attend. In the event that a child or other family member has been exposed to herpes zoster (shingles), please contact Camp for further guidance.

8. Children or family members who have received oral polio vaccine within six weeks of a camp session cannot attend.

If a camper does not meet these guidelines, please contact the Camp Sunshine office directly so the situation can be further assessed.

It is the intent of Camp Sunshine to provide respite for your patients and their families with as little medical intervention as possible. A physician will be present at Camp to provide evaluation of acute problems. No treatment will be offered at Camp other than management of routine childhood illnesses and minor injuries. Transportation will be provided to a nearby medical facility in the event that other treatment is necessary. It is not the intent of Camp Sunshine to provide routine medical care for other family members.

Thank you for helping us to provide a unique respite experience for your patients and their families. It is our expectation that children will be qualified as acceptable for referral by their own treating physicians with the above specifications in mind. Children who do not meet the above guidelines will find it inconvenient to receive needed medical care in this setting and should not be encouraged to attend. Please contact the Family Coordinator with any questions regarding the above or any aspect of medical support available for Camp participants at 207-655-3800 between 8:30am and 4:30pm Monday through Friday.

Please submit a fully completed application to:
Camp Sunshine
35 Acadia Road
Casco, ME 04015

Phone: (207) 655-3800    Fax: (207) 655-3825
http://www.campsunshine.org
CAMP SUNSHINE FANCONI ANEMIA PHYSICAL EXAMINATION FORM

The following information must be provided by the pediatric hematologist/oncologist treating the patient.

Please return to Camp Sunshine: 35 Acadia Road, Casco, Maine 04015  P: (207) 655-3800  F: (207) 655-3825

THIS APPLICATION CANNOT BE PROCESSED UNTIL ALL THE INFORMATION BELOW IS COMPLETE.

FA Patient’s Name ____________________________  Date of Examination: ___ / ___ / ___
Diagnosis: ____________________________  Date of Diagnosis: ___ / ___ / ___
Allergies: ____________________________________________________________

1 Fanconi anemia
Is the patient on active treatment?
☐ Yes  Dates and nature of most recent therapy: ____________________________________________________________
☐ No  Date therapy completed: ___ / ___ / ___

Describe any recent admissions or serious illnesses: ____________________________________________________________

List of surgeries: ____________________________________________________________

Has the patient been under the care of a psychiatrist?  ☐ Yes ☐ No  Please describe any behavioral, social, emotional, or psychiatric issues that may affect the patient: ____________________________________________________________

2 Central venous access
Type of access:  ☐ External (Broviac/Hickman)  ☐ Internal (Portacath/Infusaport/Mediport)  ☐ Not applicable

Special instructions regarding central line/port: ____________________________________________________________

3 Water Activities/Contact Sports
Can the child swim in a chlorinated indoor pool?  ☐ Yes  ☐ No
Can the child swim in lake water?  ☐ Yes  ☐ No
Can the child engage in contact sports?  ☐ Yes  ☐ No
Can the child climb on our climbing wall?  ☐ Yes  ☐ No
Can the child participate in high elements on our ropes course?  ☐ Yes  ☐ No
Are there any restrictions or suggestions for this child? ____________________________________________________________

Describe any disability or physical limitations affecting other camp activity: ____________________________________________________________

4 Transfusions
Is the patient on a transfusion protocol?  ☐ Yes ☐ No  Is the patient likely to require transfusion during camp?  ☐ Yes ☐ No
Has the patient ever had a transfusion reaction?  ☐ Yes ☐ No  Transfusion history of note ____________________________________________________________

What are guidelines for transfusion? ____________________________________________________________

What preparation or pre-medication is required? ____________________________________________________________

5 Hematopoietic stem cell transplantation
Has the patient undergone stem cell transplantation?  ☐ Not applicable  ☐ Bone marrow  ☐ Peripheral stem cell  ☐ Cord blood

Donor:  ☐ Related  ☐ Unrelated  Date of transplant ___ / ___ / ___

Have there been any complications related to the transplant? ____________________________________________________________

6 Varicella (If the following information is not complete, this application cannot be reviewed.)

Please indicate:

_____ (1) This patient is IMMUNE to varicella by reason of (check one or more):
☐ clinical disease  ☐ positive titer  ☐ Varivax vaccine  – OR –

_____ (2) This patient is NOT IMMUNE to varicella and the vaccine has not been administered to him/her.

IN THE EVENT OF A VARICELLA EXPOSURE AT CAMP, WILL THIS PATIENT REQUIRE IVIG AND/OR ACYCLOVIR?  ☐ Yes  ☐ No
PHYSICAL EXAMINATION

Height: ________  Weight: ________  Pulse: ________  Respirations: ________  BP: _____/_____  

Please note all abnormal findings. Check “✓” indicates normal.

HEENT ______________________________________ Musculoskeletal/Back __________________________

Neck ______________________________________  Genitalia _______________________________________

Lungs ______________________________________  Neurologic _____________________________________

Heart ______________________________________  Skin ___________________________________________

Abdomen ____________________________________  Prostheses? ________________________________

Comments: ____________________________________________________________

LABORATORY INVESTIGATIONS

Date: _______ H/H _____/_____ WBC ________  (ANC ________)  Platelets ________  

Chemistries: ___________________________________________________________ Urinalysis:_______________

Will the patient require laboratory tests while at camp? If so, please specify which tests and to whom results should be called/forwarded. (Please limit these to essential studies.) _____________________________________________________

MEDICATIONS*

WITH THE EXCEPTION OF WEEKLY METHOTREXATE, CHEMOTHERAPY IS NOT ADMINISTERED AT CAMP.

Please list medications that the patient receives routinely (include pain management). Attach additional pages if necessary.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Route</th>
<th>Frequency</th>
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*Each family should bring all medications, catheter dressings, and other necessary supplies.

IS THERE ANYTHING ELSE WE SHOULD KNOW THAT WOULD BETTER ASSIST US IN PREPARING FOR THIS FAMILY TO ATTEND CAMP? IN PARTICULAR, ARE THERE ANY SOCIAL OR EMOTIONAL CONCERNS PERTAINING TO ANY FAMILY MEMBER? _________

We regret that applications cannot be reviewed unless the signature of the attending hematology/oncology physician or certified oncology nurse practitioner is provided below. Thank you for your cooperation!

I have examined ___________________________ who is physically able to engage in camp activities except for the limitations and restrictions noted above.

Attending physician’s/nurse practitioner’s signature: __________________________ Date __________

Type/print name: ________________________________________________________________

Address: _________________________________________________________________

Telephone: (____) _______________________ Fax: (____) _____________________________

Telephone or pager where a physician who is familiar with the patient can be contacted at night and on weekends: (____) _____________________________

PLEASE NOTIFY US OF ANY LAST-MINUTE CHANGES (I.E., MEDICATIONS, LAB RESULTS) ON A LATE CHANGES FORM.
Health History Form

Please complete pages 1 and 2 of this form for each person attending other than the camper. Information must be filled out by a parent/guardian for all minors. Any changes to this form should be provided to Camp Sunshine staff prior to arrival.

Name __________________________     Birth date ___________     Age: _______ Gender: ___________________

Relationship to camper __________________________     Parent/guardian (if applicable) __________________________

Name (in full) as you would like it to appear on the nametag ___________________________________________

Address __________________________     City _______________________     State ________     Zip ________

Insurance Information
Is the participant covered by family medical/hospital insurance?  yes  no
Carrier or plan name _________________________     Policy No. ____________     Group No. ______________

Medications
Please list all medications taken routinely. Bring enough medication to last the entire camp session. Keep all medication in original packaging/bottle that identifies the prescribing drugs.

Med #1_____________________Dosage_____________Specific times taken each day__________________
Reason for taking__________________________________________

Med #2_____________________Dosage_____________Specific times taken each day__________________
Reason for taking__________________________________________

Med #3_____________________Dosage_____________Specific times taken each day__________________
Reason for taking__________________________________________

General Questions (Explain “yes” answers)
1. Have you had any recent injury, illness, or infectious disease?  yes  no
2. Do you have a chronic recurring illness/condition?  yes  no
3. Have you ever been hospitalized?  yes  no
4. Have you ever had surgery?  yes  no
5. Have you ever had a head injury?  yes  no
6. Have you ever been knocked unconscious?  yes  no
7. Have you ever passed out during exercise?  yes  no
8. Have you ever been dizzy during exercise?  yes  no
9. Have you ever had a seizure?  yes  no
10. Have you ever had chest pain during or after exercise?  yes  no
11. Have you ever had high blood pressure?  yes  no
12. Have you ever been diagnosed with a heart murmur?  yes  no
13. Do you have diabetes?  yes  no
14. Do you have asthma?  yes  no
15. Have you ever had an eating disorder?  yes  no
16. Have you ever had emotional difficulties for which professional help was sought?  yes  no

Please explain “Yes” answers, noting the number of the questions: ____________________________________________

____________________________________________________________________________________

____________________________________________________________________________________
____________________________________________________________________________________

____________________________________________________________________________________
Camper’s name ______________________

Name __________________________

Allergies

Describe reaction and management of the reaction

Medication allergies (list)

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

Food allergies (list)

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

Other allergies (list)

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

Dietary Restrictions

☐ Does not eat pork        ☐ Does not eat eggs        ☐ Does not eat dairy

☐ Other (describe) _____________________________

Explain any restriction to activities (e.g. what cannot be done, what adaptation or limitations are necessary)

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

Use this space to provide any additional information about participant’s behavior and physical, emotional, or mental health about which camp should be aware:

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

To the best of your knowledge, which of the following has the participant had?

☐ Chickenpox ☐ Measles ☐ German Measles ☐ Mumps ☐ Hepatitis A ☐ Hepatitis B

☐ Hepatitis C ☐ TB Mantoux Test Result: ☐ Positive ☐ Negative

Name of family physician: ___________________________ Phone________________

*(YOU DO NOT NEED A PHYSICIAN’S SIGNATURE)

Parent/Guardian/Adult Authorizations: This health history is correct and complete as far as I know. The person herein described has permission to engage in all camp activities as noted.

I hereby give permission to Camp Sunshine’s medical personnel to provide any and all reasonable and necessary medical treatment for the person herein described. I further understand and consent that I am responsible for all medical expenses incurred by Camp Sunshine on behalf of the person herein described.

Signature of custodial parent/guardian or adult camper ___________________________ Date ____________

Printed Name ___________________________ Date ____________